Transcript Details
This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/if-telemedicine-for-the-routine-assessment-of-pah-patients-is-the-new-deal-are-we-getting-the-most-out-of-it/14123/

Released: 06/24/2022
Valid until: 06/24/2023
Time needed to complete: 1h 01m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

If Telemedicine for the Routine Assessment of PAH Patients Is the “New Deal”, Are We Getting the Most Out of It?

Dr. Elwing:
So, if telemedicine for routine assessments of PAH patients is the new deal, are we getting the most out of it? And I think that's an important question we have to ask. Good enough is not good enough. We have to make it as productive and effective as we can. But now let's talk about how we can do that.

As you know, risk assessment in pulmonary hypertension is multimodal. We have to look at biochemical markers, so people need to get labs. We need to do clinical assessments, so we need to talk to patients. We have to have enough face time that we're able to look at functional class, symptoms, right heart failure, changes. And we need to do some sort of exercise assessment. We need to look at echocardiographic features and we occasionally need to look at hemodynamics. And we have to put that all together to be able to appropriately risk assess our patients.

How can we do this? Can we really do this in the setting of telemedicine? Progress in PAH has focused strategies for combination therapy and escalation of treatments. In 2018, revised treatment strategies were based on severity of the newly diagnosed PAH patients by those multiparametric risk stratification models. In risk stratification, clinical, exercise tolerance, RV function, hemodynamic parameters were all looked at to define patients as low, intermediate, or high risk based on their one-year mortality. The 2018 treatment algorithm defines initial treatment strategies based on those risks. And with those risks, we would determine, do you need monotherapy, dual therapy, or triple therapy? So we cannot do this without proper risk assessment. And we need to be able to reevaluate to drive patients to low-risk status.

Let's take a look at some of our risk tools. We have here the Swedish registry, the French, and COMPERA. And all have one thing in common. If we are able to get patients to low risk and maintain low risk, patients do well. If you can see here in the Swedish registry, the low-risk patients or those who improved to low risk had an 89% or better survival at five years. The same in the French registry. And COMPERA also showed, the lower your risk, the better your survival.

How can we adapt with telemedicine? Risk assessment protocols like REVEAL Lite 2 make maximum out of these noninvasive parameters. And we could use this for our telemedicine approach to PAH care. REVEAL Lite 2 was developed using the same data as REVEAL 2.0. It was based on REVEAL 2.0 but uses only six noninvasive and modifiable parameters. We look at functional class, blood pressure, heart rate, walk distance, BNP, and renal function. And with that, patients are then divided into low-, intermediate-, and high-risk groups, just like in REVEAL 2.0.